U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Denver Region

FINAL REPORT

Wyoming Children's with Developmental Disabilities

Control #0253.90.R2.02

June 17, 2009

Executive Summary:

The Centers for Medicare Medicaid Services CMS conducted a quality review of the Wyoming Home and Community Based Services (HCBS) waiver serving children with developmental disabilities from birth through 20 years of age. As a result of the evidence submitted by the State and information gathered since approval of the waiver the State demonstrated compliance with all six assurances required for waiver approval as set forth in 42 CFR §441 subpart G.

This HCBS waiver originated in July of 1992 and is currently operating in its third renewal period effective July 1, 2005 through June 30, 2010. The waiver is operated by the Wyoming Department of Health Developmental Disabilities Division. The Division is a separate section under the same department as the single State Medicaid agency the Office of Health Care Financing.

CMS conducted the review in accordance with the Interim Procedural Guidance (IPG) which has been in effect for assessing home and community based waiver programs since January of 2004 with the latest revision effective February of 2007. One of the main purposes of the IPG was to standardize the approach CMS utilized when assessing waiver programs as it transitions its quality oversight approach to one that incorporates both the assurance of statutory requirements and promotion of quality improvement.

We found the State to be in compliance with all six assurances required for waiver approval. However, we recommend the State consider seeking technical assistance from Thomson-Reuters to assist the State in developing performance measures and remediation/improvement processes for its Quality Improvement Strategies to ensure the waiver renewal is sufficient to monitor ongoing compliance with statutory requirements and to facilitate systemic quality improvement.

Introduction:

Pursuant to 1915(c) of the Social Security Act the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community based services as an alternative to institutionalization. The CMS has been delegated the responsibility and authority to approve State HCBS waiver programs.
The CMS must assess each home and community based waiver program in order to determine that State assurances are met. This assessment also serves to inform CMS of possible issues in its review of the State s request to renew the waiver In accordance with federal regulations at 42 CFR §430.25(h) (3) the renewal request must be submitted to CMS at least 90 days before the currently approved waiver expires. The CMS strongly recommends that the State submit the renewal through the web based 1915(c) HCBS application process which will save the State time and efforts in submitting future amendments and renewals.

State Waiver Name:	Wyoming Children's with Developmental Disabilities Home and Community Based Waiver
Administrative Agency:	Wyoming Department of Health, Office of HealthCare Financing
Operating Agency:	Wyoming Developmental Disabilities Division
State Waiver Contact:	Beverly Swistowicz, ABI & Child Waiver Manager
Target Population:	Developmentally disabled children
Level of Care:	Intermediate care facility for mentally retarded persons with related conditions
Number of Waiver Participants:	Current waiver Year 4, effective 7/1/08 - 6/30/09, the State was approved to serve 835 unduplicated recipients, and 835 for waiver year 5.
Average Per Capita Waiver Costs:	Current waiver Year 4, the annual estimated average waiver cost per person, as amended, was approved at 16,796; and waiver year 5 was approved at $16,796.
Effective Dates of Waiver:	7/1/05 – 6/30/10
Approved Waiver Services:	Case Management; Initial Assessment; Subsequent Assessment; Homemaker; Personal Care; Respite; Residential Habilitation Trainer; Specialized Family Habilitation Home; Residential Habilitation; Environmental Accessibility New; Environmental Accessibility Repair; Nursing; Medical Equipment and Supplies New; Medical Equipment and Supplies Repair; Dietician; Respiratory Therapy
CMS Contact:	Trinia Hunt, Financial Management Specialist, Denver Regional Office

I. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in the approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, nursing facility, or ICF/MR.
Authority: 42 CFR §441.301-303; State Medicaid Manual (SMM) 4442.5; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The State substantially met this assurance.

Evidence Supporting this Conclusion:

The Wyoming Developmental Disabilities Division (DDD) determines clinical eligibility for the waiver through the psychological evaluation and Inventory of Client and Agency Planning (ICAP). The ICAP is administered by an independent contractor, Wyoming Institute for Disabilities (WIND). Financial eligibility is determined by the Department of Family Services. After clinical and financial eligibility are determined the LT-MR-104 form is used to determine the Level of Care for all applicants for the Adult Developmental Disabilities (DD) waiver.

The Level of Care form is also completed annually to assure the waiver participant still meets an ICF/MR level of care when the annual service plan is submitted to the DDD for approval. These forms are completed by the case manager with information on the diagnosis and level of support and supervision taken from the psychological evaluation medical documentation for a related condition and the ICAP.

Although the State provided information on the processes and monitoring activities related to this assurance it also submitted the required evidence and its own Remediation/Action Plan in which to address State identified issues. The following evidence and Remediation/Action Plan were submitted by the State that demonstrated compliance with this assurance:

Evidence: Sub-Assurance #1: An evaluation for level of care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.

1. 246 children applied for the Children's DD Injury Waiver in Fiscal Year 2007.
    A. 22% (54) of applicants did not complete the eligibility process for the waiver.
    B. 8% (19) of applicants were found ineligible.
    C. 16% (40) of applicants were found eligible and are receiving waiver services.
    D. 35% (86) of applicants were found eligible but have been put on a waiting list.
    E. 2% (4) turned 21 before eligible could be determined but they made application for the Adult DD waiver.
    F. 17% (43) of applicants are still pending.
2. 241 children applied for the Children's DD Injury Waiver in Fiscal Year 2008.
    A. 4% (8) of applicants did not complete the eligibility process for the waiver.

B. 6% (15) of applicants were found ineligible.
C. 3% (7) of applicants were found eligible and are receiving waiver services.
D. 35% (70) of applicants were found eligible but have been put on a waiting list.
E. 2% (3) turned 21 before eligible could be determined but they had made application for the Adult DD Waiver.
F. 57% (138) of applicants are still pending.

3. Before the service plan was submitted to the Division for approval, 100% (39 in 2007 and 8 in 2008) level of care (LT-MR-104) forms were completed for each applicant receiving a funding opportunity by his/her chosen case manager.
A. If an error was found on the LT-MR-104 form, the Waiver Specialist contacts the case manager for corrections.
B. No plans were approved without a complete level of care determination.

Wyoming Remediation/Action Plan for Sub-Assurance #1:

To explain a gap identified in their system, referring to Evidence items 1 and 2, A and F above, Division staff discussed the number of applicants who did not complete the eligibility process or are still pending in fiscal years 2007 and 2008 for the Children's DD Waiver. Staff noted that families usually have various reasons for not completing the process, not choosing a case manager, changing their minds, moving out of State, etc. However, the Division does not have a system in place to determine why a person has not progressed in the eligibility process in two months or more. Therefore, no Division staff routinely followed up on an applicant unless he/she resurfaced through a phone call to the Division, a crisis, or by word of mouth from a provider or a concerned citizen.

To help improve the Division's follow up on applicants to assist them in getting needed services, Division staff proposed developing a tickler system in an electronic application database. The system would track dates of application and dates of choosing the case manager, and if more than two months go by with no further action, then a reminder for follow up would be sent to the Area Resource Specialist. The electronic application system will be web-based and implemented at approximately the same time as the electronic plan of care. The proposed timeline for implementation is January 2010. Until the web-based system is developed the Division will continue to manually check the current database to identify applicants who have not chosen a case manager in a timely manner and complete follow-up with these applicants.

In reference to Evidence item 1 and 2, D, there is a growing concern with the waiting list for services. The Division is working with the Department of Health to identify possible solutions. The Governor's budget does not include additional funding for the Children's DD waiver waiting list. The Division is working with the Department of Health to identify possible solutions. The Division has also developed a Real Choice Support Waiver to provide support services to people currently on the waiting list.

In reference to Evidence item 3, no service plans were approved without qualifying clinical eligibility documentation, financial eligibility, and a complete level of care determination, but the Division did not collect data on the number of level of care forms that were incorrect and

returned to the case manager. Waiver specialists began tracking this information for plans beginning July 1, 2008. For July, August and September 2008, no plans for children new to the plan were submitted.

Evidence: Sub-Assurance #2: The level of care of enrolled participants is reevaluated at least annually or as specified in the approved waiver.

1. In Fiscal Year 2008, 100% (792) Children's DD Waiver participants had LT-MR-104 forms (Level of Care) completed by the case manager before the submission of the annual service plan.
2. 100% (1280) annual service plans, which included the Level of Care determination form, were reviewed by a Waiver Specialist at the Developmental Disabilities Division before the service plan was approved.
    A. If the form was incorrect then the waiver specialist contacted the case manager for corrections.
    B. The form was then resubmitted to the Division before the plan was approved.
    C. No plans were approved without a complete level of care determination.
3. Beginning July 2008, waiver specialists documented the number of level of care determination forms that needed to be corrected. During the first quarter of fiscal year 2009, 11% of LT-MR-104 forms needed some correction; all of these were corrected before the plan was approved by the waiver specialist.

Wyoming Remediation/Action Plan for Sub-Assurance #2:

In reference to Evidence item 3, although no plans were approved without a complete level of care determination, the Division did not collect data on the number of forms that were returned to the case manager until fiscal year 2009. The first quarter data did not identify any trend. The forms were returned for various reasons due to processing errors: from forgetting a signature, to not completing all components, to not to sending the form. As further data is collected, and a pattern emerges, training will be designed either for the specific case manager or state wide if it is a systematic trend. The Division is developing a more formal quality improvement strategy. This will be in place at the time of renewal. The Division will be reviewing this form and looking at revising it when the waiver is renewed. In addition, the proposed web-based electronic plan of care would eliminate these errors since the plan would not be submitted until all components were completed. This information will continue to be reviewed. If a trend is noticed, follow-up consultation will be made by waiver staff to resolve the problem and offer training on the form.

Evidence: Sub-Assurance #3: The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

1. 100% (792) of Children's DD waiver service plans were reviewed for the following eligibility requirements, as required by the Wyoming Children's DD waiver:
    A. Psychological evaluation
    B. ICAP

C. Financial eligibility as reported in MMIS
D. LT-MR-104

2. Eighty-six (86) children left waiver services during the 2008 fiscal year. Thirty seven (37) turned 21, and all but two (2) participants moved to the Adult DD waiver. Fifteen (15) children and their families moved out of State.
3. One child no longer met the clinical eligibility during the 2008 fiscal year. The Children's DD Waiver Manager followed the loss of eligibility rule and process in the Wyoming Medicaid Rules Chapter 42. The individual received an Adverse Action/Denial of Eligibility letter, which included information on the right to a Fair Hearing.

Wyoming Remediation/Action Plan for Sub-Assurance #3:

In reference to Evidence items 2 and 3, although the existing database can report the number of children who left waiver services, it is difficult to capture the reason for leaving. About half of the participants who leave the waiver do so because they have turned 21 years old and transition into the Adult DD waiver. Some families leave the State or no longer desire waiver services. Very few children leave due to no longer meeting the clinical eligibility requirements.

The Division has been working with the Wyoming Department of Health Information and Technology (IT) Division for over a year to develop an electronic plan of care, and the ability to collect data, such as the reason for leaving the waiver, will be built into this system. The proposed timeline for implementation is January 2010.

CMS Recommendations:

CMS recommends the State be consistent with how the waiver under review is referred to; Children's with Developmental Disabilities as opposed to Children's DD Injury Waiver.

CMS recommends double-checking the numbers provided in the Evidence Sections for Sub Assurances 1, 2 and 3 related to this Quality Assurance. For example:

Evidence Item #3 for Sub-Assurance #1: Before the service plan was submitted to the Division for approval, 100% (39 in 2007 and 8 in 2008) level of care (LT-MR-104) forms were completed for each applicant receiving a funding opportunity by his/her chosen case manager. However, the numbers provided for 2007 and 2008 do not correspond to evidence items #1 and #2 for Sub Assurance #1. The aforementioned evidence items indicate the numbers should be 40 in 2007 and 7 in 2008.

Evidence Item #2 for Sub-Assurance #2: 100% (1280) annual service plans, which included the Level of Care determination form, were reviewed by a Waiver Specialist at the Developmental Disabilities Division before the service plan was approved.

- How did the State arrive at this number?
- Please identify the time-period this statistic represents.

Evidence Item #2 for Sub-Assurance #3: Eighty-six (86) children left waiver services during the 2008 fiscal year. Thirty seven (37) turned 21, and all but two (2) participants moved to the Adult DD waiver. Fifteen (15) children and their families moved out of State.

- Please explain what happened to the two (2) participants that did not move to the Adult DD waiver.
- The breakout above does not equal 86 rather 55. Why did the other thirty-one participants leave the waiver in 2008? Are they still receiving services?

Wyoming Remediation/Action Plan for Sub-Assurance #1:

- What happens when the waiver participant does not want a case manager?
- How does the State ensure freedom of choice?
- Besides the creation of the Real Choice Support Waiver what other methodologies are being examined to decrease the waiting list?

Wyoming Remediation/Action Plan for Sub-Assurance #2:

- Please address how data will be gathered and analyzed until the "more formal quality improvement strategy is developed and implemented."
- CMS commends the State for recognizing a data gap and encourage you to continue gathering and analyzing information regarding completeness of LOC forms. In this endeavor, recognizing patterns and trends is imperative for ensuring continuous quality improvement.

Evidence Item #3 for Sub-Assurance #3:

- In the case of the one child who was determined ineligible how was the change in condition identified? What was the outcome of the case and was it resolved?
- What actions is the State taking to ensure there are not other cases of a similar situation?

Wyoming Remediation/Action Plan for Sub-Assurance #3:

- Does the State gather information on why families no longer desire waiver services? Surveying families on their motivation to withdraw can provide avenues for improvement of the waiver.
- CMS commends the State for pursuing an electronic plan of care, which would enhance data collection however, it is essential that the State continue to collect data manually in the interim.

State Response:

Evidence Item #3 for Sub-Assurance #1:

- The State apologizes for the error, the corrected statement is before the service plan was submitted to the Division for approval, 100% (40 in 2007 and 7 in 2008) level of care (LT-MR-104) forms were completed for each applicant receiving a funding opportunity by his/her chosen case manager.

Evidence Item #2 for Sub-Assurance #2:

- The State apologizes for the error, the corrected statement is on Fiscal Year 2008, 100% (792) annual service plans, which included the Level of Care determination form, were reviewed by a Waiver Specialist at the Developmental Disabilities Division before the service plan was approved. The State arrived at this number by tabulating the number of plans that were entered into the Access database in Fiscal Year 2008. Fiscal Year 2008 is from July 1, 2007 through June 30, 2008.

Evidence Item #2 for Sub-Assurance #3:

- The State apologizes for the error, the corrected statement is: Seventy-eight (78) children left waiver services during the 2008 fiscal year. Forty-six (46) turned 21, and all but (1) moved to the Adult DD waiver. The one (1) who did not move to the Adult Waiver did not feel that continued waiver services were necessary. Twenty (20) children and their families moved out of state, eight (8) children passed away. Three (3) chose not to continue waiver services and one (1) was no longer eligible after testing. This information is collected by reviewing each file. It will be electronically captured when the electronic plan of care is implemented.

Wyoming Remediation/Action Plan for Sub-Assurance #1:

- The State requires all waiver participants have a case manager.
- The State ensures freedom of choice in a number of ways. There is a notice of choice form that is signed by the participant and/or guardian that states the individuals have been given a choice of providers. This form is submitted with the plan of care. No plan is approved without this form. Team meeting notes are completed after each team meeting the ARS attends. During these team meetings, freedom of choice is discussed. These notes are shared with Waiver Managers, Waiver Specialists and Survey/Certification staff. Monthly data collected, indicates if choice was/wasn't offered. The Plan of Care requires the participant or guardian to sign a Freedom of Choice form. This form indicates that they have been given the opportunity to choose a different provider. Area Resource Specialists attend at least 20% of all team meetings and verify choice has been given
- The DD Division is considering systems changes within the waivers focusing on methods to lower average costs per person, allowing the Division to serve more people while still providing appropriate supports and services to people currently receiving services. However, with the economic downturn, the Division continues to work closely with Medicaid, the Department of health and the Governor's office to evaluate services for new participants.

Wyoming Remediation/Action Plan for Sub-Assurance #2:

- The data on level of care determination forms that need correction continues to be collected on an Excel Spreadsheet. As reported, the 1st quarter of Fiscal Year 2009, 11% of forms needed some correction. The 2nd quarter was 8%, and the 3rd quarter was 10%. The State is collecting information only on if the form requires any correction. Many times, these corrections are clerical in nature such as forgetting to write the date or complete all the required information. These clerical corrections will be corrected in the electronic plan of care since the document would not be able to be submitted with missing information.

Evidence Item #3 for Sub-Assurance #3:

- The child was found clinically ineligible due to increased functional ability as measured by the ICAP assessment. The family was notified by certified letter with a copy to the case manager. This letter included the right for a hearing, none was requested. The child continues to receive services through the local school district. The family was offered services through the state respite program but did not pursue that option.
- The State reviews every psychological assessment and ICAP report when the plan of care is submitted annually. There are occasional situations where the child has made improvement and no longer qualifies for services. The State follows the notification procedure when this happens.

Wyoming Remediation/Action Plan for Sub-Assurance #3:

- At this time the state does not gather information on why families no longer desire waiver services. It is a very small number, less than ½% of children receiving services. The waiver program is a voluntary program and families and/or the participants have the ability to state that they no longer wish to receive this service.

CMS Final Response:

- The CMS will follow-up with the State to clarify what systems changes and methods it is considering within its waiver to lower average costs per person.
- The CMS recommends the State consider seeking technical assistance from Thomson-Reuters to assist the State in developing performance measures and remediation/improvement processes for its Quality Improvement Strategies to ensure the waiver renewal is sufficient to monitor ongoing compliance with statutory requirements and to facilitate systemic quality improvement.

II. Service Plans are Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants.
Authority: 42 CFR §441.301-303; SMM 4442.6; SMM 4442.7; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The State substantially met this assurance.

Evidence Supporting Conclusion:
The service plan also called the Individual Plan of Care (IPC), serves as the authorization for the waiver services for a participant on the waiver. Providers cannot provide and bill for services until they have been selected by a participant and until the plan of care has been approved by the Developmental Disabilities Division. The plan of care normally covers a period of one year. Although there are situations when the plan may cover less than a year, a plan never will exceed a year. Once the plan of care is finalized, providers will receive a copy.

It is a provider's responsibility to understand the services and supports outlined in the plan of care. Included in the plan is the pre-approval form.

The process used in determining services for the Children's DD waiver uses a person-centered approach to assure the personal goals and interests of the participant are included in the planning of services. The case manager must thoroughly identify the participant's demographics, waiver and non-waiver service needs, medical information, and ongoing health and safety concerns. The plan also requires a description of the participant's supervision and support needs in various areas, places and times, based on the psychological report, ICAP and medical information. If the participants demonstrates maladaptive behaviors identified in the assessments or in the plan, then a positive behavior support plan is required. Objectives and schedules are required for each habilitation service on the plan and must reflect the health, safety, and goals and interests of the participant.

Case managers are not employed by the State. They are either employed by a Medicaid waiver provider organization certified to provide case management services, or are independently certified as a Medicaid waiver provider to provide case management services, or independently certified as a Medicaid waiver provider to provide case management services. Case managers are responsible for developing and submitting a service plan for a participant once a year. The case manager must coordinate at least two team meetings a year related to a participant's service plan, once to develop the annual plan of care, and a six-month plan review meeting. An Area Resource Specialist from the Division attends several participant meetings every year and acts a fiscal steward for the Division.

All service plans are submitted to the Division by the case manager at least twenty days before the plan start date. Each service plan is reviewed annually by a Waiver Specialist and approved before services are delivered or reimbursed.

Like noted in the previous section, the State also submitted the required evidence and its own remediation and action plan in which to address identified issues. The following evidence and Remediation/Action Plan were submitted that demonstrated compliance with this assurance:

<u>Evidence:</u> Sub-Assurance #1: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

1. In Fiscal Year 2008, 100% (792) plans for each waiver participant were reviewed by a waiver specialist to assure:

A. The service plan addressed the supervision and support needs of the participant based on information from the psychological evaluation, ICAP, other assessments if included, and medical, health and safety concerns listed.

B. The "About Me" section questions were answered with participant and/or guardian input and reflected the participant's goals, likes, dislikes, interests, hobbies, and natural supports.

C. The objectives and schedules reflected the personal goals, interests, and health and safety information listed elsewhere in the plan.

D. Services on the plan, both waiver and non-waiver, were appropriate for the participant's needs.

E. A positive behavior support plan was included when maladaptive behaviors were identified in the assessments or elsewhere in the service plan.

2. Beginning with the July 2008 plans, the Children waiver specialists began keeping data on the issues that needed correction before the plans could be approved. For the first quarter, comment sheets were sent on 138 out 200 (60%) plans submitted. The following sections of the plan of care needed the most comments:

A. 11% of plans needed correction to the LT-MR-104

B. 14% of plans needed correction on the Rights section

C. 19% of plans needed correction on the Positive Behavior Support Plan

D. 25% of plans needed correction on Objectives

3. All correction to the plans of care were made and approved before the plan of care was approved by the Division.

Wyoming Remediation/Action Plan for Sub-Assurance #1:

After the Wyoming Medicaid rules were promulgated in December 2006, the case managers and Division staff were required to work in compliance with the new rules. This impacted the service plan approval system and required a new collaboration with the Division and case mangers to learn the rules, use the new provider manual for additional guidance, and build service plans with more detail and cohesiveness than previously required.

Waiver specialists worked diligently on reviewing service plans in accordance with the rules, but case manages were not fully knowledgeable of the rules and did not submit plans that were fully in compliance. Therefore, to build the collaborative and consultative relationship with providers, Division staff tried to educate case managers and other providers to correct problem areas of the plan by phone consultation, comment pages, and through Division trainings. After all areas of concern were addressed, plans were approved without disrupting services for the participant.

In January 2007, the Children DD waiver staff began using a database to track the plans which required a comment page to be sent. However, the categories of the problems identified were not quantified.

In identifying the key problematic areas of the plan, the Division formed working groups with various stakeholders in November 2007 to discuss the rules, plan guidelines and forms to make clear expectations to those areas of the service plan. In working these areas with stakeholder and Division staff, Division managers were able to finalize policy and procedures and revise the service plan instructions to be more consistent, compliant, and streamlined across all three Medicaid waivers at the Division.

The Division updated the service plan forms to correspond with the new expectations and requirements the Division implemented based on input from the working groups. The new service plan was introduced during two April 2008 provider trainings and has been required for all plans beginning on or after July 1, 2008.

In response to Evidence item 1 E, the Division contracted with a psychologist to provide training on writing Positive Behavior Support plans during the summer of 2008. A total of 96 individuals were trained in nine communities.

In response to Evidence item 2, waiver specialists began tracking categories of comments for plans beginning July 1, 2008. Since data has only been collected for 3 months, no trend has been identified. Waiver specialists consult with each case manager to correct the identified issues. This data will continue to be reviewed. If a trend is identified, follow up consultation will be made by the waiver staff to resolve the problem and offer training.

Other enhancements to the service plan will be implemented when the Division switches to an electronic plan of care, currently under development and scheduled for implementation in January 2010. One area or gap the Division plans to address with the electronic plan of care is to assess more non-waiver supports and services used or available to the participant. Currently, the service plan has the case manager mark a box if non-waiver services are used. Standard non-waiver services are listed, such as SSI, SSDI, food stamps, and housing, and the service used is underlined. Although a few extra boxes are available to be marked for services not listed, rarely are other services described or marked. The electronic plan is also going to assess and capture information in other gaps we have identified such as participant risks, natural supports, and structure for developing a positive behavior support plan and objectives.

In some cases, when the service plan does not fully address a health, safety or medical need of the participant, the Division will make a referral to APS Healthcare. This organization will investigate and advise a participant's team on extraordinary circumstances, health and safety concerns, complaints, or other protocols to explore in serving a person in a community setting.

Evidence: Sub-Assurance #2: State monitors service plan development in accordance with its policies and procedures.

1. 100% (792) of all plans were reviewed by a waiver specialist to assure the plan submitted were in accordance with the Division's policies and procedures. Any concerns found were communicated to the case manager and corrected before the plan was approved.
2. Area Resource Specialists attended 26% (389 out of 1500) of all Children's DD Waiver team meetings for fiscal year 2008.
    A. During fiscal year 2008 there were two internal referrals from Area Resource Specialists regarding Children's DD waiver providers.
    B. One internal referral involved case management compliance. The concern was substantiated and the provider was required to submit a quality improvement addressing the non-compliance.
    C. Survey/Certification unit of the Division monitored implementation of the quality improvement plan to assure the provider addressed the non-compliance appropriately.

Wyoming Remediation/Action Plan for Sub-Assurance #2

The Division held an all staff meeting in July 2007, so staff in the different units of the Division could identify gaps in the system, including service plan development and plan

approval. Information on gaps identified at this meeting and comments made by case managers and providers during site surveys resulted in many items needing to be addressed. Primarily, the expectations of the waiver specialists in approving plans did not coincide with how service plans were developed by the participant's team and case manager.

One approach used to help narrow the gap between plan development and plan approval by Division staff was to revise the service plan guidelines, or instructions, that are available to providers as a tool in plan development. The guidelines being used were developed before the rules were promulgated in December 2006, so they were not fully encompassing all of expectations set forth in the rules. Therefore, the plans submitted to the Division had gaps in them.

In November 2007, the Division created working groups involving providers, case managers and various waiver staff from different units to address key problematic areas of the plan of care to come to a consensus on certain items and develop more specific criteria and instructions in other areas to make the plan easier to develop in accordance with the rules.

In reference to Evidence item 1, in March 2008, the revisions to the service plan instructions were made, distributed to providers, and posted to the Division's website. Provider training on the changes and service plan expectations was facilitated by the Waiver Managers to inform them about the changes, expectations, and tools available. Training was completed in April 2008 through video conferencing and DVDs of the training with developing positive behavior support plans, objectives, and discussing right restrictions with participants and families, the Division has developed tools to post on its website, which offer prompts for discussion, key areas to address, and sample formats to use.

In addition, the Division completed regional training throughout the State in spring and summer 2008 to address gap areas in plan development. Topics include: team meetings, transitions, and IPC instructions. The Division also contracted with a psychologist to conduct regional training in the summer 2008 on writing positive behavior support plans and performing a functional analysis for a behavior plan.

The Division management staff will meet in the fall 2008 to identify and schedule additional trainings for calendar year 2009.

Evidence: Sub-Assurance #3: Service plans are updated or revised at least annually or when warranted by changes in the waiver participant's needs.

1. 100% (792) of service plans for each waiver participant were reviewed and approved by a Waiver Specialist to assure the participant's needs and wishes were addressed as fully as possible and the plan complies with the rules.
2. 100% of all modifications submitted to the Division are reviewed by the Waiver Specialist, although not all of them were approved. Reasons for not approving a modification to the service plan included:
   1) A modification that did not meet the participant's health, safety, or medical needs, or

2) A modification that included a non-certified service provider, or
3) The modification amount exceeded the Individually Budgeted Amount (IBA) for the participant, then:
    i. The modification went to ECC to seek approval for additional funding, or
    ii. The modification was withdrawn by the case manager.

3. Of the 792 of Children's DD Waiver plans approved by the Division during fiscal year 2008, 4% (32) used the ECC process to approve funds above the IBA to meet service needs for the participant.
    A. 4% (22) of all 792 Children's DD waiver participants received some additional funding as a result of the ECC process.
    B. Five of these cases required follow-up monitoring as requested by the Children's DD waiver.
    C. All were receiving services as approved through the ECC process.

Wyoming Remediation/Action Plan for Sub-Assurance #3:

While providers are learning the new rules and expectations required in the service plan, Waiver Specialists and waiver Manager have also been consulting on an individual basis with case managers. The Division has identified training for case managers as a priority in 2009. Training modules and regional training will be scheduled.

Through the provider recertification process and the complaint process, the Division continues to identify concerns with lack of documentation or insufficient documentation by case managers' specifying how they are monitoring the implementation of plans of care, completing follow-up on concerns found with implementation, and making changes to the plan as needed. The Survey/Certification Unit of the Division revised the case managers' monthly quarterly documentation tool to provide more clear guidelines on specific type of monitoring and documentation case managers are required to complete. This tool was completed and distributed on September 9, 2008 and re-education of case managers on the requirements for monitoring implementation of plans of care and completing follow-up on concerns or changes needed to the plans will be completed by October 2008.

Evidence: Sub-Assurance #4: Services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

1. In fiscal year 2008, Area Resource Specialists attended approximately 26% (389 out of 1500) of annual, six month, or other team meetings for participants on the Children's DD waiver, providing guidance and education.
2. The Survey/Certification unit of the Division completed annual recertification of 100% of the certified Children's DD waiver providers (675) in fiscal year 2008, including, when appropriate, review of implementation of plans of care for participants. The Division does not currently track recertification by type of waiver. The following data is from all providers recertified by the Division.
    A. 3% (63) of the waiver providers received recommendations during their recertification due to concerns with implementation of plans of care.

I. 100% of the providers, who received a recommendation in this area, were required to submit a quality improvement plan to address the concerns with the implementation of the plans of care.

II. The Survey/Certification unit completed follow-up monitoring on 100% of the cases to assure the concerns were addressed.

B. 1% (22) received recommendations identifying concerns with case managers' documentation and follow-up on concerns in the monthly/quarterly reporting requirements.

I. 100% of these providers were required to submit a quality improvement plan to address the concerns with their documentation.

3. The Survey/Certification unit completed received 28 complaints involving participants on the Children's DD waiver in fiscal year 2008.

A. 11% (3) of the complaints indicated case management non-compliance with rules and regulations, including concerns with monitoring implementation of the plan of care.

B. None of these complaints were substantiated.

4. A questionnaire was mailed to Children's DD waiver families through the National Core Indicator Project for fiscal year 2008.

A. 84% of the respondents marked that their case manager seemed "always or usually" knowledgeable about the service options offered by the Division.

B. 95% of the respondents marked that they were satisfied with services and supports "always or usually"

C. 86% of the respondents marked that they were "always or usually" satisfied with the services their case manager provides to you.

Wyoming Remediation/Action Plan for Sub-Assurance #4:

In early 2006, the Division identified concerns with case managers' documentation of monitoring the implementation of plans of care. While documentation was being completed, it was often not specifically identifying concerns or follow-up actions taken to address concerns. This was most notably identified in the area of case management review of utilization of services for each participant, and health/safety changes such as weight loss or gain, changes in seizure activity etc. Effective July 1, 2006 the Division revised the ISC monthly/quarterly requirements and sample form on the Division's website to more specifically include this information.

While completing monitoring duties the Survey/Certification Unit has identified improvements in this area and the number of recommendations specific to case management documentation is decreasing. The result is that case managers are more thoroughly documenting the results of their review of the implementation of the plan of care and, when concerns are found, what follow-up actions are completed to address the concerns and whether these follow-up actions addressed the concerns.

However, through the provider recertification process and the complaint process, the Division continues to identify concerns with lack of documentation or insufficient documentation by case managers' specifying how they are monitoring the implementation of plans of care,

completing follow-up on concerns found with the implementation, and making changes to the plan as needed. The Survey/Certification Unit of the Division has revised the case managers' monthly quarterly documentation tool to provide more clear guidelines on the specific type of monitoring and documentation case managers are required to complete. This tool was completed and distributed September 9, 2008 and re-education of case managers on the requirements for monitoring implementation of plans of care and completing follow-up on concerns or changes needed to the plans will be completed by October 2008.

The Area Resource Specialists (ARS) continue to provide education and feedback during the plan of care meetings, and they are identifying significantly fewer concerns with review of implementation of plans of care. Team meeting notes are completed after each team meeting the ARS attends. These notes are shared with Waiver Managers, Waiver Specialists and Survey/Certification staff. Monthly data collected, indicates that choice was/wasn't offered, that fiscal concerns were discussed, and health and safety issues were discussed and resolved. Monthly data from team meeting notes also reflects any provider compliance issues.

The Division does not review data collection to ensure quantifying data accurately reflects the percent of providers who received recommendations on training. The Division is working with the Wyoming Department of Health Information and Technology (IT) Division to restructure our database so it is more streamlined and easier to extract data.

Based on the collaboration, the Division is working with IT to develop a Comprehensive Provider Management System that will streamline both the tracking of individual monitoring activities and aggregating and analyzing data by waivers, by provider, by categories, and by priority levels.

The timeline for the system is as follows:

- Proposal for system completed by January 2008
- Contract finalized in February 2008
- First components of system developed and tested by April 2008
- Second major components of system developed and tested by June 2008
- Final major components of system developed and tested by August 2008
- First reports generated by October 2008.

During this development process Survey/Certification staff with the DDD will continue to track data in the current databases.

<u>Evidence:</u> Sub-Assurance #5: Participants are afforded choice: 1) between waiver services & institutional care; and 2) between/among waiver services and providers.

1. In fiscal year 2007, 28% (353) of all team meetings on all three waivers attended by Area Resource Specialists were transition meetings.
   A. From January through June 2008, 5% (40) of team meetings attended by Area Resource Specialists were transition meetings for the Children's DD waiver. The transition process verified that participants and families were offered choice and exercised their right to change providers.

2. 100% (794) of all Children's DD plans approved in fiscal year 2008 have a "Notice of Choice" form signed by the participant and/or guardian verifying that choice of provider had been given.

Wyoming Remediation/Action Plan for Sub-Assurance #5:

Although data is collected on the number of transition meetings attended, data by waiver only began being collected in January 2008 referring to Evidence item 1 above. Transition meetings are required when a participant changes case manager or residential habilitation providers. Non-compliance with the transition requirements increase the health and safety risks of participants as they move from one location to another or one service provider to another. Therefore, the Division will review the data to determine if a case manager is failing to comply with the transition rules. If this is found, the Survey/Certification Unit will require the provider to submit a quality improvement plan and will monitor the provider's compliance with the plan.

Recently, Area Resource Specialists started collecting data at team meetings regarding a participant or guardian's response in verifying that choice was offered. Beginning July 2008, this data will be collected per waiver. The Division will review the data to look for trends to determine if a specific provider is not routinely offering choice. If this trend is found the provider will be required to submit a quality improvement plan specifying how they are going to comply with the requirement to offer choice. The Survey/Certification unit of the Division will monitor the provider's compliance with the quality improvement plan.

CMS Recommendations:

Wyoming Remediation/Action Plan for Sub-Assurance #1:
CMS commends the State for identifying key problematic areas in their plan and forming working groups with various stakeholders to address.

- Were waiver participants and/or their family members a part of this working group?
- How is the State going to address other problems that surface in this area in the future?
- How is the State going to assess whether the streamlined approach translates to better service planning an implementation for the individual?

CMS commends the State for contracting a psychologist to provide training on writing Positive Behavior Support plans.

- How is the State going to measure the outcome of these plans and ensure the plan adequately addresses maladaptive behavior and translates to better service planning for the waiver participant?
- Although 96 individuals were trained in nine communities, who makes up the 96 trained, and what percentage was trained?
- Based on your evaluation of the effectiveness of Positive Behavior Support plan training, how will you continue this learning process?

The State indicated in some cases, when the service plan does not fully address a health, safety or medical need of the participant, the Division makes a referral to APS Healthcare.

- When assessing the APS Healthcare reports, please provide data in the numeric form versus using terminology such as "some reports" for evidence.
- Is there written criterion to guide the Division as to when to activate APS Healthcare?
- How many waiver participants have been referred to APS Healthcare and what were the results?

Evidence Item #2C for Sub-Assurance #2

- Please elaborate on how the Survey and Certification Unit monitors the implementation of the quality improvement plan.
- Did the provider address the non-compliance appropriately?
- What happened with the other internal referral mentioned in evidence item 2A?
- Were these the only referrals for the waiver period under review (July 1, 2005 – Present)

Evidence Item #3B for Sub-Assurance #3

- For the five (5) cases the required monitoring what did the follow-up entail?

Evidence Items 2A and 2B for Sub-Assurance #4

CMS recommends double-checking the numbers provided in the aforementioned evidence sections for Sub Assurance #4 related to this Quality Assurance. Using the numbers provided by the State, CMS came up with different percentages. Specifically, the waiver providers who received recommendations during their recertification due to concerns with implementation of plans of care and those providers who received recommendations identifying concerns with case managers' documentation and follow-up on concerns in the monthly/quarterly reporting requirements. CMS results were respectively 10% and 3% not 3% and 1% as reported.

Evidence Item 4 and Sub-Assurance #4

CMS commends the State for being involved with the National Core Indicator Project for fiscal year 2008. The percentages reported represent a high satisfaction level from respondents. However, the State did not include the number of surveys that went out or how many were returned. Please provide so that CMS can have a better understanding of the client satisfaction.

State Response:

Wyoming Remediation/Action Plan for Sub-Assurance #1:

- No, participants and families were not involved as part of the working groups. The problems identified were issues with case managers either not understanding the expectations or expressing the need for more training.
- Since the Division is now keeping data on problematic areas of the plan of care that need correction, the Division will analyze the data and make recommendations on training. The Division implemented the first training for new case managers in March 2009. This training will continue on a quarterly basis. There will be regional training on the plan of care during the Spring and Summer of 2009. The intended audience will be not only case managers but also participants, families, and other waiver providers.

- The Division will continue to analyze problematic areas in the plan of care with the expectation that the percentage of plans not requiring correction will increase. The Division will also evaluate satisfaction forms from the regional trainings

- Since the Division is now keeping data on problematic areas of the plan of care including the positive behavior support plan, the Division will analyze the data and make recommendations on training. In addition, beginning July 2009, the Division will collect data on the number of plans on the Children's DD Waiver that include positive behavior support plans. The Division will also collect data on the plans that include restraints and/or restrictions.
- It is difficult to quantify the case managers who attended since the State does not currently certify each case manager. However, at least one case manager from thirteen (13) CARF accredited organizations attended the training. Fourteen (14) independent providers attended the training. There are twenty-one (21) CARF accredited organizations providing case management and seventy-five (75) independent case managers. All case managers will have their own provider number by December 31 2009.
- Training on the Positive Behavior Support plan was incorporated into the training for new case managers held March 2009. The DD Division will continue to offer training to all case managers via video conference, webinar, and in person regional training. The training will include real life exercises to help case managers work with team members in writing an appropriate Positive Behavior Support Plan.

- The contract with APS Healthcare provides comprehensive case management, chronic illness management, and prevention and wellness services to the Wyoming Medicaid population. Currently the reporting requirements for this contract do not include reporting the number of referrals or outcomes by program. Beginning in October 2008, the Office of Healthcare Financing streamlined the referral process to ensure timely response and more efficient tracking of referrals. By July 1, 2009, the Developmental Disabilities Division will develop guidelines to describe when staff will make a referral to APS Healthcare due to a concern identified in the services plan. The Office of Healthcare Financing will work with the Developmental Disabilities Division to track participant referrals and results for this waiver.

Evidence Item #2C for Sub-Assurance #2
The Survey/Certification unit monitors implementation of each quality improvement plan through one or more of the following processes, depending upon the type of recommendation made:

- On-site visit to verify implementation of the quality improvement plan for recommendations identifying significant concerns with health, safety or rights that can only be monitored through on-site reviews
- Review of documentation, including, for example, revised policies and procedures, documentation of trainings, documentation of current CPR/1st aid certifications, to verify implementation of the quality improvement plan for recommendations identifying non-compliance with rules and regulations

- Interviews with participant, guardian, provider and/or provider staff to verify implementation of the quality improvement plan for recommendations identifying non-compliance with implementation of the plan of care that do not identify significant concerns with health, safety or rights.
- Follow-up during the provider's next recertification

The results of the monitoring are tracked through IMPROV, the DD Division's provider management system.

- The Survey/Certification unit of the Division monitored the provider's quality improvement plan to assure the provider was giving proper notice of team meetings to the Division as well as the guardian and other team members and was adhering to the team meeting guidelines in developing the plan of care. The provider has implemented her quality improvement plan appropriately and has addressed these concerns.
- The second internal referral that identified possible non-compliance did not involve case management services or the development of the plan of care and was not substantiated so no further action was necessary.

No. Below is information on internal referrals for the Children's DD Waiver for July 1, 2005 through June 30, 2007:

- 21 referrals made to the Survey/Certification unit in Fiscal Year 2006 and Fiscal Year 2007
    - 12 of these referrals identified concerns with case management compliance with rules and regulation
    - 0 of these referrals were substantiated
- The Division identified a gap with the internal referral process. Division staff was referring concerns to the Survey/Certification unit without assessing the validity of the concerns, the severity of the concerns, and without identifying the area of non-compliance. The Division has revised the internal referral process to include education of case managers if there are minor concerns or mistakes made when submitting plans of care or when facilitating team meetings. Staff documents these educations in team meeting minutes or in comment pages back to the case managers. If the case manager continues to have difficulties complying with the rules and regulations in these areas a referral is then made to the Survey/Certification unit for follow-up. The process includes immediate referral if there are health and safety concerns. This change in process was fully implemented in Fiscal Year 2008 and the result to date is the number of internal referrals has decreased and the validity of the referrals has improved significantly. This is evidenced by the substantiation of one of two internal referrals completed for the Children's DD Waiver. The second referral, although it did not concern case management services, did indicate some concerns with billing that were later not substantiated.

Evidence Item #3B for Sub-Assurance #3

Of the five Children's DD Waiver cases that required monitoring:

- Three required on-site visits to assure the additional funding was being utilized appropriately and the additional supports approved were being provided. All three on-site visits found no concerns.
- Two required progress reports from the provider on the status of the services. No concerns were found with the progress reports.

Evidence Items 2A and 2B for Sub-Assurance #4

- The Division apologizes for these errors. The correct percentages are 10% of the waiver providers received recommendations during their recertification due to concerns with implementation of plans of care and 3% (22) received recommendations identifying concerns with case management documentation and follow-up on concerns in the monthly/quarterly documentation.

Evidence Item 4 and Sub-Assurance #4

A total of 711 surveys were sent to Children's Waiver parents/guardians and 186 were returned for a 26% return rate. Not all returned surveys had all of the questions completed so each question had a total that was slightly less than 186.

- For question A: there were 180 complete answers and 151 case managers were considered knowledgeable (84%).
- For question B: there were 183 complete answers and 174 were satisfied with their services and supports (95%).
- For question C: there were 183 complete answers and 157 were satisfied with the services the case manager provided (86%).

CMS Final Response:

- The CMS recommends the State consider seeking technical assistance from Thomson-Reuters to assist the State in developing performance measures and remediation/improvement processes for its Quality Improvement Strategies to ensure the waiver renewal is sufficient to monitor ongoing compliance with statutory requirements and to facilitate systemic quality improvement.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
Authority: 42 CFR §441.302; SMM 4442.4; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The State substantially met this assurance.

Evidence Supporting Conclusion:

Like in the previous two sections, the State provided information on the processes and monitoring activities related to this assurance. More importantly, it also submitted the required evidence and its own remediation and action plan in which to address identified issues. The following evidence and Remediation/Action Plan were submitted to demonstrate compliance with this assurance:

Evidence: Sub-Assurance #1: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services.

1. 151 new providers were certified for Children's DD services during fiscal year 2008. 100% of the providers met the qualifications for services and completed the Waiver Provider Manual training.
2. 100% of 675 providers certified to provide Children's DD services were recertified during fiscal year 2008. The Division does not currently track recertification recommendation by type of waiver. The following data is from the recertification of all providers certified by the Division.
   A. 78% (528) of these providers received at least one recommendation.
      I. The most common recommendations made were to address non-compliance with required policies and procedures, drills/inspections, and with incident reporting requirements.
         a. 100% of the providers receiving a recommendation were required to submit a quality improvement plan addressing the area(s) of non-compliance.
         b. 100% of all quality improvement plans were monitored for compliance by the Survey/Certification Unit of the Division to assure that the areas of non-compliance were addressed appropriately.

3. The Division suspended 5 providers certified to provide Children's DD services during fiscal year 2008.
   A. 2 suspensions were due to providers' failure to submit quality improvement plans to address areas of non-compliance. The providers chose to decertify as a provider.
   B. 1 suspension was due to provider failing to obtain CARF accreditation resulting in decertification of the provider.
   C. 1 suspension was due to substantiation of abuse/neglect from the Department of Family Services and resulted in decertification of the provider.
   D. 1 suspension was due to assault charges being filed against the provider whose case is still pending in the courts. The provider remains suspended and cannot provide services.

4. 41% (28) of the complaints received concerned Children's DD waiver services.
   A. The Survey/Certification Unit categorized and investigated 100% of the complaints:
      I. 12 involved provider or case management compliance with rules/regulations.
         a. 2 of the complaints were substantiated.
      II. 9 billing/documentation concerns.
         a. 3 of the complaints were substantiated.
      III. 5 identified potential health and safety concerns.
         a. 2 of the complaints were substantiated.
      IV. 2 involved service quality.
         a. 1 of the complaints was substantiated.
      V. 2 were level I complaints that resulted in reports to the Department of Family Services and on-site visits.

a. 100% of the complaints substantiated resulted in the provider submitting a quality improvement plan to address the areas of non-compliance.
b. The Survey/Certification Unit monitored implementation of the quality improvement plan to assure the concerns were addressed.

5. The Area Resource Specialist completed 2 referrals to the Survey/Certification Unit due to concerns with Children's DD waive provider compliance.

A. 1 of the referrals (50%) identified concerns with case management compliance was substantiated.

I. The provider was required to submit a quality improvement plan to address the area of non-compliance and the Division monitored implementation of the quality improvement plan to assure the concerns were addressed.

B. 1 of the referrals (50%) identified concerns with billing that was not substantiated.

6. The Mortality Review Committee has reviewed seven (7) of the thirty-two (32) deaths that occurred between January 1, 2007 and December 31, 2007. Two of those seven deaths were children receiving services on the Children's DD waiver:

A. One case remains open and more information has been requested on the case.

B. The other case was closed with no recommendations.

Wyoming Remediation/Action Plan for Sub-Assurance #1:

The Division promulgated rules in December 2006, including rules that specified provider requirements, certification and recertification requirements, and sanctioning authority. The rules include specific policies, procedures and processes that Non-CARF providers are required to develop. Throughout the rest of fiscal year 2007, Program Integrity staff worked with Non-CARF providers to assist them in developing these policies and procedures. In addition to the one-on-one assistance given to Non-CARF providers by Division staff, the Division has also developed sample policies and procedures for providers to reference. The most recent data indicates that the percentage of recommendations addressing non-compliance with policies and procedures is decreasing. A formal measure of this information will be completed in July 2008.

Provider and provider staff knowledge of the incident reporting requirements continue to be a major concern. As of August 2007, the Division began requiring providers to receive training on incident reporting from the Division when significant concerns with adhering to the incident reporting requirements were found. From January through August 2008, eleven regional trainings were conducted. In addition, the Division has completed a module on incident report training has begun distributing the module on DVD or develop their own trainings that covers all the requirements included in the Division's trainings. The Division monitors compliance with this requirement during the provider recertification process.

The Division will continue to collect and analyze data on incident reporting requirements to determine if these action steps are addressing the concerns.

The Division continues to work with providers on the billing and documentation requirements. Effective January 2006, the Division began a formal process of reviewing documentation standards with providers and providers became required to sign a copy of the current documentation standards after this review. Division staff continues to educate providers on the requirements when concerns are found during recertification or complaints. The Division has also strengthened the process of referring cases to the Office of Healthcare Financing (Medicaid) for possible recovery of funds. Improvements in this process included developing a referral cover sheet requiring Survey/Certification staff to submit specific information on the referral to Medicaid requiring Survey/Certification staff to submit copies of the signed documentation standards and documentation of education completed with the provider prior to the recovery with the referral so it is clear that the provider had been trained on the documentation standards and requiring that Medicaid provide the Division a copy of the recovery letter so the Division can assure the recovery has been completed. The eleven regional trainings conducted from January through August 2008 contain a module on documentation.

The Division currently has a system monitoring process for this assurance, but is in the processing of enhancing data collection, tracking and analysis to assure that data is valid and reliable and to improve staff efficiency.

Evidence: Sub-Assurance #2: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Wyoming does not allow non-certified providers to provide any services under the Adult DD Waiver.

Evidence: Sub-Assurance #3: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

1. During the time-period of July 2007 through June 2008, the Division provided various training topics to participants, families, guardians, providers, outside agencies, and the Division's advisory board.
2. Training flyers and listserv emails were sent to the previously mentioned entities describing the training sessions.
3. Listed on the following chart are the training sessions conducted by various DDD staff:

Name of Training	Type of Media	Audience	Division Staff	# of sessions
Plan of Care, Rights, Positive Behavior Support Plans, PRNs, Objectives	Video Conference	Case Managers and other Providers	Waiver Managers	2
Plan of Care Update-Rate Changes	Video Conference	Case Managers and other Providers	Waiver Managers	2
CARF training-sponsored by DDD	Conference	Case Managers Division Staff	CARF Staff	3
Applications, Incident Reporting, Complaints, Recertification, Confidentiality, Documentation	Regional Meetings	Case Managers and other Providers	Area Resource Specialists and Survey/Certification Staff	6
Team Meetings and Transitions	Regional Meetings	Case Managers and other Providers	Area Resource Specialists	8
Team Meetings	1:1 or small group	Case Managers, schools, other State Agencies	Area Resource Specialists	18
Application Process	Small group	Case Managers	Area Resource Specialists	3
Positive Behavior Support Plans	Small group	Case Managers and Division Staff	Contracted Psychologist	9
*Initial Provider Training	In person or by phone conference	All new providers	Survey/Certification	151

4. No provider applicant received their provider ID enrollment number until they completed the Initial Provider training and signed a form stating as such.
5. There were 151 new providers certified to provide services on the Children's DD waiver who received the training on the provider manual from July 1, 2007 through June 30, 2008.
6. Quality Improvement Surveys of providers showed:
   A. 16% (311) of the providers recertified received at least one recommendation concerning staff training.
      1. All providers were required to submit quality improvement plans to address the areas of non-compliance
      2. The Division monitored implementation of the quality improvement plans to assure the areas of non-compliance were addressed

Wyoming Remediation/Action Plan:

Survey Certification staff enter the provider training recommendations into an Access database. This information is reviewed quarterly by management and Survey Certification staff to identify any trends. Both positive and negative trends are identified. The positive trends are reviewed to determine the impact of remediation actions the Division has taken in specific areas and to identify the strengths within our system. The negative trends are reviewed to

identify appropriate action steps to take to address the trends. The management staff then agrees on methods to create change if the trends are of a negative nature.

The information derived from the database is shared with stakeholders to review and make suggestions for change. Stakeholders include the DDD Advisory Council, providers, participants and families. Through sharing the information on trends and areas of concern, the Division seeks to resolve the matters through forming working groups, developing new tools or guidance for provider or Division staff, or gathering input for making a system change in the new waiver application.

Training modules to accommodate providers for rule requirements are not fully completed. To address this issue, the Division will continue to develop and publish training DVDs to offer to providers in order for them to meet Chapter 45 rule requirements. The Division will also provide regional training across the state as another avenue for providers to meet Chapter 45 rule requirements. The training DVD modules will be completed by December of 2008. Regional trainings are scheduled monthly through October 2008. Although attendance is not mandatory for the regional training, a provider is required by rule, to receive training as listed in Chapter 45. This can be accomplished by watching the DVD, then writing a summary of the module, and placing it in their file. The Survey/Certification unit will review these at the time of recertification.

The Division will continue to provide training for all new providers. We will also complete training DVDs and regional training on specific information that is required by Chapter 45 of the Division rules. Our website will include a yearly calendar of upcoming training sessions.

The Division does not review data collection to ensure quantifying data accurately reflects the percent of providers who received recommendations on training. The Division is working with the Wyoming Department of Health Information and Technology (IT) Division to restructure our database so it is more streamlined and easier to extract data.

Based on the collaboration, the Division is working with IT to develop a Comprehensive Provider Management System that will streamline both the tracking of individual monitoring activities and aggregating and analyzing data by waivers, by provider, by categories, and by priority levels.

The timeline for the system is as follows:

- Proposal for system completed by January 2008
- Contract finalized in February 2008
- First components of system developed and tested by April 2008
- Second major components of system developed and tested by June 2008
- Final major components of system developed and tested by August 2008
- First reports generated by October 2008.

During this development process, Survey/Certification staff will continue to track data in the current databases.

CMS Recommendation:

Evidence Item #2 for Sub-Assurance #1
CMS appreciates that the State has identified an issue with not tracking recertification recommendations by waiver type. The evidence submitted states "the most recent data indicates that the percentage of recommendations addressing non-compliance with policies and procedures is decreasing. A formal measure of this information will be completed in July 2008." Please submit the information collected by this formal measure and supply data that verifies the decrease in non-compliance with policies and procedures by April 30, 2009.

Evidence Item #4 for Sub-Assurance #1
Recommend double-checking the number provided in the aforementioned evidence section for Sub Assurance #1 related to this Quality Assurance.

- The complaint categories the State provided do not add up to 28 rather 30.
- Does the Division receive complaints from any other source besides the Unit?
- Is 28 the total universe of complaints received?
- In preparation for the renewal application, please reference the HCBS Quality Framework in Version 3.5 Instructions, Technical Guide and Review Criteria. The HCBS Quality Framework includes the quality management functions of discovery, remediation and improvement. The Division completed the discovery and remediation functions as noted in the evidence. However, the Division does not address how this information can be taken to the next step in quality assurance (improvement) to decrease provider non-compliance on an ongoing basis.

Evidence Item #6 for Sub-Assurance #1
The evidence submitted occurred between January 1, 2007 and December 31, 2007. This only includes one year of data when three years of the waiver have expired.

- How many deaths, in total, involved children receiving services on the Children's DD waiver for the current waiver period?
- How many deaths, in total, involved children receiving services on the Children's DD for the current waiver period did the Mortality Review Committee review?
- What actions is the State taking after the Mortality Review Committee reviews the deaths of children receiving services on the Children's DD waiver to ensure the health and welfare of waiver participants?
- Does the Mortality Review Committee have a time limit for completing their review of the deaths of children receiving services on the Children's DD waiver? Is the delay in obtaining information from the Committee a barrier to the Division's ability to complete assurance processes?
- Does the State have any updates on the case that has been open for over two years?

State Response:

Evidence Item #2 for Sub-Assurance #1

- The DD Division's Survey/Certification staff continues to work with providers on assuring they have current policies and procedures in place and are adhering to those policies and procedures.
    - For Fiscal Year 2008 there were 376 out of 895 providers certified who received recommendations concerning non-compliance with policies and procedures (42%).
    - From July 1, 2008 through March 30, 2009 there were 31 out of 610 non-CARF providers recertified who received recommendations concerning non-compliance with policies and procedures (5%), which is a significant decrease from the previous fiscal year and indicates providers are better understanding the requirements and adhering to their policies and procedures.

Evidence Item #4 for Sub-Assurance #1

- There were 28 complaints filed with the Division. Two of these complaints were prioritized as level one complaint that indicated significant concerns with health and safety.
- The Division compiles data on both complaints and internal referrals. Complaints are received from outside entities such as guardians, participants, providers, community members, provider staff, family members etc. The Division does accept anonymous complaints. Internal referrals are concerns with non-compliance by other Division staff that result in a referral to the Division's Survey/Certification unit for investigation.
- Although it was not made clear in the evidence report, the data from complaints was reviewed, significant trends were identified and actions taken to address the trends. The categories of complaints received most often were concerns with case manager compliance with rules and regulations (12 complaints) and provider compliance with billing/documentation (9 complaints). While not all of these complaints were substantiated the Division did identify concerns with case management knowledge of the rules and regulations as described in the Service Plan section of the Evidence Report. The Remediation/Actions Taken Section under Qualified Providers describes actions taken to improve the concerns with provider compliance with documentation and billing. The Division continues to enhance the quality improvement processes to assure data is being analyzed and appropriate action taken on gaps found.

Evidence Item #6 for Sub-Assurance #1

- Total number of deaths on the Children's DD Waiver from July 1, 2005 through December 2008 was 17.
- The Mortality Review Committee has completed the review of all of these deaths.
- The Mortality Review Committee can make provider specific recommendations and/or systemic recommendations. For the 17 deaths on the Children's DD waiver there were no provider specific recommendations made and 2 systemic recommendations made. The systemic recommendations were:
    - To improve the process for referral to APS Healthcare for children with high medical needs.
    - To formalize the process for risk assessments for children
- Beginning in October 2008, the Office of Healthcare Financing streamlined the referral process to ensure timely response and more efficient tracking of referrals. By July 1,

2009, the Developmental Disabilities Division will develop guidelines to describe when staff will make a referral to APS Healthcare due to a concern identified in the services plan. The Office of Healthcare Financing will work with the Developmental Disabilities Division to track participant referrals and results for this waiver.

- There is a process for risk assessment. The individualized plan of care (IPC) developed by the participant's team must have input from the participant in the "About Me" section on things the participant likes, wants in their life, and does not want in their life. Through these series of questions, the plan of care form has cues for the case manager to facilitate conversation about unhealthy habits, risky behavior, and important changes the person wants to make in their life.
- To further expand upon the input from the participant and guardian on risks in the "About Me" section, the DD Division uses the Supports, Medical Information, and Positive Behavior Support plan sections of the IPC to address risks and construct support plans. The functional limitations, identified risks and support needs of the participant are outlined in the areas of Communication, Self-Advocacy, Transportation, specific safety supports needed, Near Water, Community Outings, Mobility, Monitoring needed during sleeping, Money transactions, Mealtime guidelines, Dietary, Emergency situations, Toileting, Personal Hygiene, Home Supervision, Positioning, and Day Site Supervision. Special protocols for any critical medical, safety, or behavioral need will be included in the revised plan of care that will be implemented July 1, 2009. Regional training has already been scheduled for the months of May, June, July, and August 2009.
- The Division plans to further address potential risks in the electronic plan of care. On a parallel track, the Department of Health is developing an Electronic Health Record. It is planned that both systems will interface with each other. This will allow closer coordination and review for those participants that have high medical needs.

- There are several layers of review when deaths occur. Providers are required to file a Division's Notification of Incident report on the death, and to respond to additional questions about the death, including:
    - If the death was expected or unexpected
    - If 911 was called
    - If there were changes in medication over the past six months
    - If there were recent hospitalizations
- The Division reviews this information within one business day per the Division's Notification of Incident process to determine if more immediate follow-up is needed. This follow-up can include an on-site visit, referral to law enforcement or other appropriate agency, review of provider documentation or other actions to determine if the provider failed to follow Division rules and regulations. This process is separate from the Mortality Review Committee process, although the results of follow-up actions are shared with the Committee.
- The Division has also increased the standing meetings of the Mortality Review Committee to quarterly to assure deaths are reviewed in a timely manner. The quarterly meetings have been scheduled for 2009, and the plan is to have a process in place to review deaths within 12 months after they occur by the end of 2009.

- There was one case open from 2007 at the time the Children's Evidence Report was submitted in September 2008. This death had occurred in November 2007 and concerns were raised with the medications the participant was receiving at the time of his death. There were also concerns raised with possible drug usage by the family and participant, who at the time of his death was only receiving case management services on the waiver and lived at home. The committee requested additional information on this case, including a re-review of the case management notes, to determine if the case manager had taken all appropriate steps in assessing the participant's living situation. The review confirmed that the Wyoming Department of Family Services, Adult Protective Services, had been involved with the family and the family was proceeding with working with the case manager on receiving services from a rehabilitative hospital. The case was closed in November 2008.

CMS Final Response:

- The CMS recommends the State consider seeking technical assistance from Thomson-Reuters to assist the State in developing performance measures and remediation/improvement processes for its Quality Improvement Strategies to ensure the waiver renewal is sufficient to monitor ongoing compliance with statutory requirements and to facilitate systemic quality improvement.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an on-going basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.
Authority: 42 CFR §441.302-303; SMM 4442.4; SMM 4442.9; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The State substantially met this assurance.

Evidence Supporting Conclusion:

The State provided the following additional information worth noting in this section: Assuring the health and welfare of participants is achieved through many processes on many levels of the service delivery system in Wyoming.

The plan of care includes sections on rights and rights restrictions, and other health and safety information to assure that the participant is receiving the appropriate level of support while maintaining as much independence as possible. The plan of care also includes an "About Me" section where the team, with the participant identifies significant events and achievements that occurred over the past year.

Team meeting guidelines are in place to assist case managers through the team meeting process. The guidelines include a review of incidents and other health and safety concerns that need to be addressed in the plan of care.

Case managers complete a monthly home visit and observe services for each participant on their case load to assure services are being delivered in accordance with the plan of care. The monthly visit includes reviewing the delivery of services with the participant, and discussing any questions. If the case managers identify any concerns, including a participant's health and welfare, they are required to address the concerns in a timely manner.

Case managers also complete a quarterly review for each participant that includes a review of incidents that have occurred and identification of any significant changes in health status, to identify trends or areas where further follow-up is needed.

There is a potential to discover possible abuse or neglect throughout all these processes. If this occurs, all providers and provider staff as well as Division staff, have the duty to report suspected abuse, neglect, exploitation, self neglect or abandonment per Wyoming State Statutes to the Department of Family Services, Protective Services Unit or law enforcement. Wyoming State Medicaid rules also require providers to report serious injuries, injuries due to restraints, police involvement, deaths, and elopements. Incidents are reported to the Department of Family Services, Protective Services Unit, the Division, Protection and Advocacy, Inc., the guardian, the case manager, and law enforcement if applicable.

Providers and provider staff are required to complete training on the Duty to Report and the incident reporting process, to assure incidents are reported in a timely manner. Providers are expected to document follow-up on incidents that have occurred, and to analyze data and identify trends with incidents.

Effective July 1, 2006 the Division strengthened its review of incident reports to assure that providers were reporting incidents appropriately to all required agencies. The incident reporting form and web-based version were reviewed to assure that the forms include verification of contact information for the Department of Family Services. Survey/Certification staff is required to contact the DFS office to verify that a report was received on all incidents reporting suspected abuse, neglect, exploitation, self-neglect, and abandonment. Survey/Certification staff also enhanced the review of participant files during provider recertification, including review of internal incident reports and staff documentation for a random sample of participants to determine if incidents occurred that were not reported to the Division and DFS.

All providers must have a complaint process established, and are expected to work with the complainant to address the concerns in a professional manner. If during this process the complainant identifies potential abuse, neglect, exploitation, self-neglect or abandonment, the provider is required to report the incident to the appropriate authorities through the incident reporting process.

The Division also has a formal complaint process set up so a complainant can file a complaint with any Division staff and complaints can be filed anonymously. Information on how to file a complaint is included on the Division's website.

Protection and Advocacy Systems, Inc. completes Participant Rights trainings throughout the state, and includes in this training the rights of participants to be free from abuse, neglect and exploitation. In addition, Protection and Advocacy Systems, Inc. receives each incident report and, when appropriate, works with the Division to investigate the incident.

The mortality review process includes a review of all documentation of services for at least a six-month period before the death, including a review of all incidents, to determine if there were any suspicions of abuse, neglect, exploitation or abandonment.

As in the previous assurances, the State also included its monitoring activities for this particular assurance. Due to the significance of assuring the health and welfare of waiver participants, the following State monitoring activities were included as part of this report: The Waiver Specialists review the plans of care to assure that they are addressing the health and safety needs of the participants, including the "About Me" section of the plan, which reviews significant events and information from the previous year. Waiver Specialists are also copied on each incident reported to the Division so they can assure that the new plan of care submitted addresses areas of concerns identified in the incidents if appropriate.

Area Resource Specialists attend at least 20% of team meetings and assures that the team reviews incidents and discusses trends or concerns. If there is any indication of possible abuse or neglect the ARS instructs the provider or case manager to file an incident report and complete the appropriate follow-up. This information is also shared with the Survey Certification Unit, which then requires the provider to submit a quality improvement plan to assure that incidents are being reported appropriately.

The Survey Certification Unit of the Division manages the web-based incident reporting process that enables the Division to review incidents within one business day. The Division's Notification of Incident process includes:

- A web-based system for reporting incidents that includes specific information on the incident, antecedents, actions taken to assure participant's health and safety, and verification that all required agencies have received the report
- A priority level process that requires Survey Certification staff to review reported incidents within one business day to determine if an incident requires immediate follow-up (which is considered a level 1 incident)
    - When Level 1 incidents are reported, the Division has a protocol for working with the Department of Family Services, Protective Services unit and Protection and Advocacy Systems, Inc. to coordinate investigation of the incident and to share pertinent information
- Tracking incidents in the web-based system and directing appropriate Division staff to review the status of specific incidents, as well as to run reports on open incidents, incidents by provider, incidents by category etc.
- Substantiation of incidents of suspected abuse, neglect, exploitation or abandonment results in the provider or provider staff being terminated as an employee or provider.

The Survey Certification Unit manages the Division's complaint process, and reviews complaints to determine if there is any indication that abuse, neglect, exploitation and/or abandonment is occurring. If this is determined, then the complaint is reported through the Division's Notification of Incident process so that the Department of Family Services as well as the other appropriate agencies are informed.

The provider recertification process includes review of providers' documentation of services, including internal incident reports, to determine if incidents occurred that were not appropriately reported. If this is found, providers are required to report the incident, and develop and submit a quality improvement plan that addresses this area of non-compliance. The recertification process also includes interviews with providers and provider staff to determine if they are aware of their duty to report incidents.

The recertification process also includes review of a case manager's monthly/quarterly documentation to assure appropriate follow-up is completed on incidents and other health and safety concerns.

The mortality review process includes provider specific recommendations if non-compliance with rules and standards, including the incident reporting requirements, is identified.

If non-compliance with rule, regulations or standards is found through any of these processes the provider is given a recommendation and is required to address the area of concern by submitting a quality improvement plan that includes specific action steps, responsible parties, and due dates. If the recommendation identifies concerns with health and safety, the provider is required to address the significant concerns immediately and submit a quality improvement plan within 15 business days. All other recommendations require a quality improvement plan within 30 calendar days.

The Program Integrity Unit completes monitoring activities to assure the provider is adhering to the quality improvement plan submitted and approved by the Division. Failure to submit an adequate plan or failure to adhere to a plan submitted can ultimately result in sanctions, including civil monetary penalties, suspension of a provider certification, or decertification.

In addition to systems to prevent the occurrence of abuse, neglect and exploitation, the Division has developed additional safeguards to address the issues of restraints.

The following evidence and Remediation/Action Plan were submitted to demonstrate compliance with this assurance:

<u>Evidence:</u> Sub-Assurance #1: On an on-going basis, the State identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

1. 106 incidents were reported involving participants on the Children's DD waiver:
    A. Of the eleven categories for reportable incidents, the highest reported category was Police Involvement, followed by serious injuries.
2. The Survey/Certification Unit of the Division completed annual recertification of 100% of the certified Children's DD waiver providers (675) in fiscal year 2008. The Division does not

currently track recertification recommendations by type of waiver. The following data is from the recertification of all providers certified by the Division.

A. 10% (195) providers received at least one recommendation pertaining to incident reporting.

I. 100% of providers who were not in compliance in this area were required to submit a quality improvement plan.

II. The Survey/Certification Unit of the Division completed follow-up monitoring on 100% of these providers to assure that the quality improvement plan was implemented appropriately and the concerns were addressed.

3. Area Resource Specialists attended 26% of the team meetings for Children's DD waiver participants and made 2 referrals to the Survey/Certification Unit due to non-compliance concerns with Children's DD waiver services. Neither referral concerned health or safety of participants.

4. 100% (792) of the plans of care were reviewed by the Waiver Specialist who checked the services, supports, behavior plans, and medical information listed to assure the health, welfare, and participant's rights were addressed.

5. The Mortality Review process found no concerns identified with potential abuse, neglect, exploitation, or abandonment.

6. During any monitoring activity, the Division has the authority to remove participants from a provider's service if it is determined that the participant is in imminent danger. For fiscal year 2008 there were two providers serving children who were suspended due to allegations of abuse, neglect or assault:

A. One provider was providing Special Family Habilitation Home Services to a child and allegations were made that the provider physically abused the child. The child was removed from the home pending the investigation and the Wyoming Department of Family Services substantiated the charges. The provider was placed on the DFS Central Registry and was decertified as a provider.

B. One provider who served participants on the Children's DD waiver and Adult DD waiver was charged with a crime against a person that involved a participant and was suspended as a provider pending the outcome of the court case. The provider pleaded no contest and was subsequently substantiated for abuse by the Wyoming Department of Family Services. The provider was placed on the DFS Central Registry and decertified as a provider. (No mention of transition services offered to the waiver participant)

CMS Recommendation:

Evidence #1 for Sub-Assurance #1

- Please identify the reporting time-period for the 106 incidents contained in the aforementioned evidence.
- The Division submitted evidence regarding eleven categories of reportable incidents. The evidence was not as detailed as necessary to demonstrate the Division's analysis of the collected data or how it was used to determine the necessity for a remediation/improvement plan. Specifically, the State identified police involvement and serious injuries as the two highest categories out of eleven incident categories. However, the State did not include specific data regarding how many incidents involved police involvement or serious injuries. CMS was unable to determine if

remediation/improvement plan would be needed based on the submitted data. The State did not include any additional information describing a remediation/improvement plan for these types of incidents. Can the State elaborate on the decision making process to not follow through with remediation/improvement plan for the data regarding reportable incidents?

- The State's evidence did not include data that suggested there was need for incident report trainings regarding complaints although, the remediation/improvement plan indicates the State identified a gap in routinely informing guardians and participants of how to file a complaint.

State Response:

Evidence #1 for Sub-Assurance #1
The reporting time-period was July 1, 2007 through June 30, 2008.

- Below is a summary of incidents reported by category for the Children's DD Waiver:
  - Police involvement – 33 incidents (31%)
  - Serious injury - 31 incidents (29%)
  - Suspected neglect – 17 incidents (16%)
  - Suspected self abuse – 4 incidents (4%)
  - Suspected self neglect – 0 incidents (0%)
  - Suspected exploitation – 5 incidents (5%)
  - Suspected abandonment – 0 incidents (0%)
  - Injury caused by restraints – 0 incidents (0%)
  - Death – 7 incidents (7%)
  - Elopement – 5 incidents (5%)
  - Not categorized – 4 incidents (4%)– later determined to be non-reportable due to not fitting any of the reportable criteria
- The DD Division did not include a statistic from the April 2008 National Core Indicator's Child Family Survey in the Evidence Report, which reported on data collected in 2006 and 2007. 30% of the families who responded to the Child Family survey stated they were not familiar with the process for filing a complaint or grievance regarding services they receive or staff who provides them. Wyoming still scored significantly lower than the national average of 43.80% but the Division identified the trend that 1/3 of the families responding did not know the process for filing a complaint as concerning enough that it needed to be addressed through development of a handbook for families and participants.

CMS Final Response:

- The CMS recommends the State consider seeking technical assistance from Thomson-Reuters to assist the State in developing performance measures and remediation/improvement processes for its Quality Improvement Strategies to ensure the waiver renewal is sufficient to monitor ongoing compliance with statutory requirements and to facilitate systemic quality improvement.

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application.
Authority: 42 CFR §431 et seq.; 42 CFR §441.301-303; SMM 4442.6; SMM 4442.7; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The State substantially met this assurance.

Evidence Supporting Conclusion:

As part of the State's evidence submission, it described this assurance and monitoring activities as follows:

The waiver is operated by the Developmental Disabilities Division, a separate division within the Single State Agency. The Wyoming State Medicaid Agency has the ultimate administrative authority and responsibility for the operation of the waiver program. All official correspondences including waiver submission, waiver amendments, and 372 reports are reviewed and signed by the State Medicaid Agency. Although the Developmental Disabilities Division administers the day to day operation of the waiver, any changes are approved by the State Medicaid Agency and the agency is notified of any possible concerns.

All official correspondence including waiver submission, waiver amendments, and 372 reports are reviewed and signed by the State Medicaid Agency. All waiver providers are also Medicaid providers and must meet Medicaid enrollment requirements.

The State Medicaid Agency delegates approval of services to the Developmental Disabilities Division. All services must receive a prior authorization number that is assigned through the MMIS. All claims for waiver services are submitted electronically through the MMIS and all providers are paid through that system.

The Division finalized five administrative rules on waiver services in December 2006. These rules are Medicaid rules, and Medicaid staff were included as part of the stakeholder groups. Medicaid had final approval before these rules were promulgated.

There are additional monitoring activities in which a representative from Medicaid is part of the subcommittee. These include:

- **Extraordinary Care Committee** – a committee that reviews for requests for additional funding based on needs that are not identified in the model that determines the Individual Budget Amount
- **Mortality Review Committee** – a committee that reviews all deaths of waiver participants. Based on this review, both systemic and individual recommendations may be made.

In addition, a representative from the Division works with the Medicaid Program Integrity Unit to investigate any irregularities in service or billing.

Evidence: Sub-Assurance #1: The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver program by exercising oversight over the performance of waiver functions by other state and local/regional non-State agencies (if appropriate) and contracted entities.

1. Meetings with Medicaid were scheduled as needed.
   A. The Extraordinary Care Committee met weekly as needed.
   B. The Mortality Review Committee met twice a year.
2. Correspondence has been filed as required by CMS.
   A. Any concerns were reviewed by both the Medicaid Agency and the Developmental Disabilities Division.

Wyoming Remediation/Action Plan for Sub-Assurance #1:

Beginning in July 2008, Division staff participates in monthly meetings with representatives from the State Medicaid office. One meeting is sharing session where each Department of Medicaid reports on projects and issues. The second meeting is specifically for issues affecting the Division. A new staff person has recently been hired by Medicaid to coordinate all waiver issues. Meetings will be schedule in September and October 2008 to explain the waiver programs administered by the Division.

The State Medicaid Agency will continue to review and sign all official correspondence to CMS. They will continue all the monitoring activities listed in the monitoring process.

CMS Recommendations:

CMS commends the State for recognizing the need for a liaison to strengthen communications, and administrative oversight between the Department and the DD Division.

Although the State evidence packet attested that the State Medicaid exercises administrative authority for this assurance, no performance measures were identified or data submitted to verify this attestation.

Evidence #1 for Sub-Assurance #1
The evidence supplied states meetings are scheduled as needed. Two meetings identified include Extraordinary Care Committee and Mortality Review Committee. However, there was no evidence as to what transpired during these meetings or how the meetings were used to ensure administrative oversight.

Evidence #2 for Sub-Assurance #1
The evidence stated "2. Correspondence has been filed as required by CMS. A. Any concerns have been reviewed by the Medicaid State Agency and the Developmental Disabilities

Division." No additional information was provided regarding any reviews completed or the results of those reviews.

In order to demonstrate adequate administrative authority CMS recommends development of measures such as:
1. Monitoring delegated functions by including written expectations in a memorandum of understanding with the Developmental Disabilities Division; this forms the foundation for performance measures. This would allow the State Medicaid Agency to identify the delegated entity's performance: compliance or non-compliance with expectations. This also allows the Medicaid Agency to clearly identify remediation and performance improvement activities for the delegated entities.
2. Measure number and percent of waiver policies and procedures approved by the Medicaid agency prior to implementation.
3. Medicaid assurance-base look-behind data related to performance of delegated functions.

State Response:

- The Department of Health will have an Intra-Agency Agreement between Medicaid and the Developmental Disabilities Division in place by July 1, 2009. This document will replace the existing MOU and will outline the roles and responsibilities related to waiver administration and operation. It will also document the administrative authority of the State Medicaid Agent for the operation of the Children with Developmental Disabilities HCBS waiver. The Programs Coordinator, who reports directly to the State Medicaid Agent, will monitor compliance of delegated responsibilities outlined in the agreement.
- On-going review of policies, procedures, guidelines, rules, contracts, and other materials developed by the Division has been performed by the State Medicaid Agent or her designee however documentation of those reviews needs to be improved. By July 1, 2009 the Programs Coordinator and Program Integrity Manager will work together to review, solidify, and document procedures and outcomes of the reviews by the State Medicaid Agent or her designee.
- Although cumulative data is not currently kept related to performance of functions delegated through the current MOU with the Developmental Disabilities Division, oversight of those functions has been performed by the State Medicaid Agent or her designee through regularly scheduled meetings with the Developmental Disabilities Division. These meetings include but are not limited to staff meetings, management meetings, MMIS status meetings, CURT (Core Utilization Review Team), ECC (Extraordinary Care Committee) meetings, and Mortality Review Team meetings. Topics discussed are reflected in meeting agendas and minutes.

CMS Final Response:

- The CMS recommends the State consider seeking technical assistance from Thomson-Reuters to assist the State in developing performance measures and remediation/improvement processes for its Quality Improvement Strategies to ensure

the waiver renewal is sufficient to monitor ongoing compliance with statutory requirements and to facilitate systemic quality improvement.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.
Authority: 42 CFR §441.302-303; 42 CFR §441.308; 42 CFR §447.10; 42 CFR §447.200-205; 42 CFR §433; 45 CFR §74; SMM 2700.6; SMM 2500; SMM 4442.8-10; 1915(c) Version 3.5 HCBS Waiver Application and corresponding Instructions, Technical Guide & Review Criteria.

CMS Finding: The State substantially met this assurance.

Evidence Supporting Documentation:

The State provided the following overview of its financial accountability system:

The waiver uses an Individually Budgeted Amount (IBA) system to allocate resources to individuals based upon need. The Individual Budget Amount Model is named the DOORS (not an acronym) and was identified by CMS as a Promising Practice in December 2004. Using the Individually Budgeted Amount, the participant and team identifies the services requested for a plan year through development of the annual service plan. Each service request requires review and approval by Division staff.

All services must receive a prior authorization number that is assigned through the MMIS. All billing for waiver services is submitted electronically through MMIS and all providers are paid through that system. There are many edits built into the MMIS that do not allow payment for more units or dollar requests above the amount approved. System edits include service codes with set rates, limits on number of days that can be billed in a month, number of hours that can be billed in a day, and other time specific rules which limit the amount of services that can be billed.

Evidence: Sub-Assurance #1: State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

1. In Fiscal Year 2007, 100% of waiver services were prior authorized by a waiver specialist in the Developmental Disabilities Division.
2. Numbers are generated through the MMIS that are used to complete the CMS 372 reports. These numbers were double-checked against claims data within the Division to assure accuracy.
3. In Fiscal Year 2008, there were four cases referred to Medicaid Fraud Unit (MFCU) from the Division. These cases included the following:
    A. In one case, the provider refunded the monies on their own.
    B. In the second case, recoveries were completed prior to the referral to MFCU.
    C. Two cases are still pending with MFCU.

Wyoming Remediation/Action Plan for Sub-Assurance #1:

Although the financial oversight is very thorough, the Division has realized that within the Individual Budgeted Amount system, there have been negotiated daily rates. The Division has been working with Navigant Consulting, Inc. for the past two years. They have worked first to evaluate the DOORS Individual Budget Amount (IBA) model and second to assist the state in establishing a rate-setting methodology. Through the process of establishing the new rates, three cost studies, a wage survey and supplementary surveys were completed of mostly larger service providers in the state. Also, Navigant and the Division established a service provider working group to guide the rate setting process; this included 4 CARF service providers. This working group had 5 meetings to review the process and provide input. On November 1, 2007 Navigant and the Division held a meeting with the 20 largest service providers in the State to review the draft rates and provided impact analysis. The service providers had the opportunity to ask questions and provide input. Furthermore, there were four select committee meetings in calendar year 2007 in which the rate setting process and concepts were presented and the public, including service providers, families and guardians had the opportunity to comment on the rate setting process.

This standardized and consistently applied rate methodology will go into effect beginning July 1, 2008. This transition will occur over the course of the fiscal year, as each plan of care is renewed. Based on provide request, there was one telephone conference in August to answer questions about the changes. Three additional monthly telephone conferences have been scheduled. The DD Advisory committee was made aware of questions and concerns in the September 2008 meeting. As the new rates are implemented, the Division will monitor the change and effects of the new reimbursement rates.

CMS Recommendations:

Although the State evidence packet described adequate financial oversight for the assurance, no performance measures were identified.

CMS recommends development of measures such as:
1. Percentage of participant claims that are coded and paid according to the waiver reimbursement methodology.
2. Percentage of providers that maintain financial records according to provider agreements/contracts.
3. Percentage of appropriate financial records maintained as specified in the approved waiver.

Please provide the quarter(s) of the CMS-64 report in which the federal share was returned in the cases where waiver dollars were recouped, as noted in the evidence section of this assurance.

How is the State going to monitor to assure the provider network is not negatively impacted by the rate setting at the local level?

In the remediation/improvement plan, the Division realized that within the Individual Budgeted Amount system, there have been negotiated daily rates. How was this discovered? It is not addressed in the evidence.

In the monitoring process, the Medicaid Program Integrity Unit reviews a random statistically valid sample of provider waiver claims. There was no data included in the evidence regarding the results Medicaid Program Integrity Unit's reviews.

State Response:

- Of the four cases, two were paid back in quarter two of state fiscal year 2009, one was paid back in quarter three of state fiscal year 2009, and one had no recoveries.
- As a part of the new rate development process, the Division, in conjunction with the consultant, performed an impact analysis for providers to determine the outcome of the rate changes prior to implementation. The projected impact analysis showed that most providers on the Children with Developmental Disabilities waiver would not be negatively impacted.
- The Division reviews all the plans and prior authorizes each service. The Division was aware of the disparity of negotiated rates and began a two year process to develop standardized, consistently applied rates.
- The random samples include all Medicaid claims. Although data for each individual waiver has historically not been separated out, the State recognizes the value of being able to review the results by program and will work toward that end.

CMS Final Response:

- The CMS recommends the State consider seeking technical assistance from Thomson-Reuters to assist the State in developing performance measures and remediation/improvement processes for its Quality Improvement Strategies to ensure the waiver renewal is sufficient to monitor ongoing compliance with statutory requirements and to facilitate systemic quality improvement.